Name: XXX
Address: XXX
Examiner: Bryant Stone, PhD
License Number: 07258

CC File No.: XXX
Dates Seen: XXX
Date of Report: XXX

Referral Source: XXX was referred from the SIU Health Center.

REPORT OF PSYCHOLOGICAL EVALUATION

Reason for Referral: XXX wanted a formal assessment of attention and learning problems to facilitate treatment planning.

Assessment Procedures

- Adult Clinical Interview
- Wechsler Adult Intelligence Scale - Fourth Edition (WAIS-IV)
- Wide Range Achievement Test – Fifth Edition (WRAT-5)
- Test of Variables of Attention (TOVA)
- Brown ADHD and Executive Functioning Scales
- Wisconsin Card Sorting Test
- Diagnostic Interview for ADHD in Adults (DIVA)
- Barkley Adult ADHD Current & Childhood Symptoms Scales – Parent & Self-Report Forms
- Collateral Interviews: XXX (client's mother), XXX
- Personality Assessment Inventory (PAI)
- Diagnostic Interview for Anxiety, Mood, & OCD & Related Neuropsychiatric Disorders (DIAMOND)
- Records Review: High school transcripts, College Transcripts, Southern Illinois University, Carbondale

Background Information

XXX is a White/Non-Hispanic, XXX-year-old female attending Southern Illinois University, Carbondale. She requested this evaluation at the recommendation of the SIU Student Health Center because she is seeking pharmacological treatment for attention-deficit hyperactivity disorder (ADHD). She indicated prior diagnoses of ADHD and specific learning disorders (SLD) in Mathematics, Reading, and Written Expression. The client provided the information in an interview on XXX and through a review of academic transcripts.

Regarding XXX's history of presenting problems, XXX reported that others first noticed she had difficulty paying attention in 3rd grade. She said her elementary school teachers first noted that she was disruptive to the other students in her class, and her teacher documented this difficulty on her report cards and discussed these issues at parent-teacher conferences. Regarding learning difficulties, she said that problems with reading, writing, and math were first noted in the 3rd grade and interfered with her ability to complete her schoolwork promptly. She said attention and learning difficulties have persisted to date and have interfered with her academic performance in college.

Concerning social history, XXX was born in XXX, Illinois, where she lived with her biological parents, two sisters (current ages XXX and XXX), and a younger brother (current age XXX) until she moved to Carbondale, IL, to attend Southern Illinois University (SIU). She currently lives with a roommate in a rented house with her dog and her sister's two cats. Regarding family relationships, XXX reported good relationships with her mother, sisters, brother, maternal grandfather, paternal grandmother, and aunt. She reported that her maternal grandmother and paternal grandfather have passed away, but she had a good relationship with them before their deaths. She reported that she experienced severe difficulties with her father growing up, including abusive interactions, but stated that their relationship has improved and is currently "good."

Concerning developmental history, the client reported no difficulties during her mother's pregnancy or her delivery and birth. She did not believe she had any problems achieving developmental milestones. XXX described experiencing physical abuse by her father, noting as an example that when she was XXX, he held

her by the throat until her mom pulled him off. She said she has a history of being bullied by peers, particularly in middle school. Finally, the client reported an experience of sexual assault during her senior year of high school and again during her freshman year of college by friends. XXX said she did not press charges or make reports of these sexual assaults. She said she knew the perpetrators but no longer had contact with them.

Regarding medical history, XXX said that she lost consciousness when she was XX years old after jumping on and falling off a bed. She indicated that her mother called an EMT, but she was not seriously injured. She denied any additional history of serious illnesses, injuries, or surgeries. The client reported that her mom and pediatrician, Dr. XXX, attempted to put her on medication for ADHD shortly after her diagnosis. However, the client reported that she refused to take the medication. As a result, she has never taken medication for her ADHD. The client said she is not currently taking any medications except melatonin before bed and occasionally ibuprofen for menstrual pain.

Regarding her educational history, XXX reported that she attended XXX, a private Catholic Pre-K-8th-grade school in XXX, Illinois. XXX said that she withdrew from XXX School in third grade after being diagnosed with ADHD and learning disabilities in math, reading, and writing because the only accommodation they offered was private in-school tutoring. The client reported she attended XXX Elementary for 4th and 5th grade and received additional accommodations. Subsequently, she attended XXX Middle School for 6th-8th grade.

During middle school, she reported that she received the following accommodations: 1) attended a separate study hall, 2) exams read aloud, 3) support from a teacher's aide for English classes, and 4) access to a private testing room for exams. Finally, she attended XXX XXX XXX High School, a private school in XXX, Illinois, for 9th through 12th grade. She reported that her accommodations at this school were the following: 1) participation in a special study hall, 2) access to a private room, and 3) extended time on tests. Her high school transcripts indicate she graduated in the spring of 2015 with a cumulative (weighted) GPA of 2.27.

However, it appears she consistently struggled in English and Math courses. In the fall of 2015 at Southern Illinois University, Carbondale, she pursued a degree in XXX XXX with a XXX Specialization. Her college transcript indicates that as of fall 2019, she had a cumulative GPA of 2.66. She has earned average or better grades in most courses, except for a math course in the fall and several courses in the spring (e.g., Human Development, Kinesiology, and History) of her sophomore year. She wants to graduate in May 2020.

Regarding employment history, XXX said that she had had part-time babysitting jobs since she was XXX years old. She indicated she began a lifeguarding job for developmentally disabled women between XXX and XXX. She said she left this job because her lifeguard license had expired, and she did not renew it. Between XX-XX, she worked at XXX as a sales associate and left because the business closed. Finally, the client said she was hired as a sales associate at XXX when she was between XXX-XXX, but she recently quit to make more time for school. Overall, the client said she performed reasonably well in all her positions. However, she said that her attention and learning difficulties frequently made her late for work and that she had difficulty organizing, multitasking, and taking her job seriously.

Regarding social relationships, the client reported having five best friends. Three of her best friends are at home in XXX, Illinois, one moved to XXX, and one is currently in Carbondale, IL. The client reported that she stays in contact with her best friends and sees them when she has the time. She said she has been in a long-term relationship with her boyfriend for two years and four months. She reported that her relationship started "rough" but that now they have a solid relationship. The client denied having a history of any other romantic relationships. She said she had no other close friends.

Regarding legal history and substance use, XXX reported that she received a ticket for underage drinking. A search of Judici.com found no records for her in Illinois. The client said that she drinks alcoholic beverages one to two times a week for relaxation. When she does drink, XXX reported that she typically drinks one to three drinks. The client acknowledged smoking marijuana daily, stating that she "smokes out of a one-hitter and only takes small hits." The client said that smoking allows her to relax sometimes but also makes her more emotional and dysphoric. The client denied using caffeine and other substances.

For prior mental health history and psychological services, the client reported a long history of depressive

episodes starting in high school and periods of anxiety that began in college. The client reported that she first went to SIU Counseling and Psychological Services (CAPS) to treat depression during her sophomore year of college and then left before running out of sessions. She reported that she returned to CAPS during her junior year of college and was diagnosed with a borderline personality disorder. The client said she left group therapy after missing two sessions.

Mental/Status Behavioral Observations: XXX was casually dressed and appropriately groomed for each testing session. She was oriented to time, place, person, day, and date. Her speech was clear and well-articulated, reflecting logical, goal-directed, and coherent thought processes. She reported that she was in a euthymic mood for most of the sessions on the days of testing, reflected by her affect, which ranged from pleasant to occasionally tense during testing. At times, the client became tearful when describing her difficulties with inattention and organization.

Regarding her specific testing behaviors, on the first day of testing, the clinician administered the WAIS, PAI, and parts of the clinical interview. The client arrived on time, was dressed in casual attire, and appeared well-groomed. The client's speech, tone, pace, and volume were within normal limits. She required no redirection nor an unusual frequency of prompting or repetition of test questions. She remained seated and demonstrated good attention and concentration throughout the session. The clinician observed good frustration tolerance with challenging tasks, as evidenced by persistence throughout the session.

On the second day of testing, she completed the WRAT-5, Barkley Self-Report Scales, Brown ADHD Scales, BDI-2, TOVA, Wisconsin Card Sorting Test, and the DIAMOND. The client arrived on time, was dressed in casual attire, and appeared well-groomed. As on the first day, the client's speech, tone, pace, and volume were within normal limits. She remained seated and demonstrated good attention and concentration throughout the session. The clinician observed that frustration tolerance to challenging tasks was good. The client and clinician took multiple breaks throughout this extended testing session.

On the third day of testing, the clinician administered the DIVA and completed the DIAMOND. She presented as before, but her mood and affect were more variable, euthymic at times and dysphoric and tearful at others. Overall, XXX appeared to extend reasonable effort during testing, and testing conditions were satisfactory (e.g., adequate light, space, privacy). Thus, readers can interpret the results of this evaluation as a valid estimate of her current levels of functioning.

Assessment Findings

Cognitive and Intellectual Functioning: XXX completed the WAIS-IV, obtaining a Full-Scale IQ (FSIQ) score of 101 in the Average range at the 53rd percentile, with a 95% probability that her true score is between 97 and 105. The FSIQ comprises four factors: The Verbal Comprehension Index (VCI), measuring her vocabulary development, abstract reasoning skills, and social judgment; Perceptual Reasoning Index (PRI), assessing skills in perceptual analysis, nonverbal reasoning, and attention to detail; the Working Memory Index (WMI), an index of immediate recall, auditory attention and cognitive control; and the Processing Speed Index (PSI), measuring visual memory, visual discrimination, fine motor skills, and psychomotor speed. The VCI (70th percentile), PRI (50th percentile), and the PSI (70th percentile) are in the Average range.

In contrast, the WMI (13th percentile) is in the Low Average range and is significantly lower than the other three index scores. This score suggests a significant weakness in working memory skills. However, the low WMI score is primarily due to her poor performance on the Arithmetic subtest, and as such, the index score may not best represent her overall auditory working memory abilities. In any case, the General Ability Index provides an estimate of intellectual functioning based exclusively on the VCI and PRI, and this score was in the Average range at the 61st percentile with a 95% probability that her true score is between 99 and 109. Thus, this score probably best reflects her overall cognitive functioning.

Strengths & Weaknesses: XXX's performance was somewhat variable across subtests. Regarding specific skills, relative strengths and weaknesses are calculated by comparing each subtest score to the client's mean (average) subtest score. General strengths and weaknesses reflect comparisons of each subtest score with the mean (average) score obtained by individuals in the standardization sample.

On the verbal tests, XXX performed exceptionally well on Similarities, a test of abstract reasoning and verbal expression, and on Vocabulary, a test of verbal expression and word knowledge. She obtained a score in the High Average range for both subtests, demonstrating a strength relative to her mean subtest score and to individuals her age in the standardization sample. In contrast, she obtained a significantly low score on Information, assessing memory for acquired academic knowledge. This score was in the Low Average range and reflected a weakness relative to her mean subtest score and the mean for the standardization sample.

On the nonverbal tests, she obtained her lowest subtest score on Block Design, in the Borderline range. This test is timed and assesses the ability to analyze and synthesize abstract visual stimuli, as well as to integrate visual and motor skills. Again, she demonstrated both a relative and general weakness. In contrast, scores for Matrix Reasoning, a test of fluid nonverbal reasoning, and Visual Puzzles, a test of visual-spatial integration and the ability to synthesize abstract visual stimuli, were both in the Average range.

Scores on the two subtests that comprise the Working Memory Index were significantly discrepant. She obtained her lowest score (across all subtests) on the Arithmetic subtest, which measures auditory attention, concentration, and ability to solve mental mathematics problems. This score was in the Borderline range. In contrast, her score on Digit Span, a test of auditory attention, immediate auditory recall memory, and mental control, was in the Average range. The scores on both processing speed tests were within the Average range. These included Symbol Search, a test of visual scanning, visual discrimination, attention to visual detail, and Coding, a test of visual memory, sequencing, and fine motor skills.

Wide Range Achievement Test–Fifth Edition (WRAT-50): I administered the WRAT-50 and scored it using the age-based norms. The WRAT-5 is a measure designed to assess academic performance in reading, spelling, and mathematics. Her scores for Word Reading (13th percentile), a test of basic decoding skills and word recognition, Spelling (14th percentile), and Math Computation (21st percentile) were all in the Low Average range. Her Sentence Comprehension score, a test of word reading in context to obtain meaningful information, was at the upper end of the Average range, at the 73rd percentile.

This test yielded a Reading Composite score in the Average range at the 37th percentile. In sum, she demonstrates weaknesses in basic reading and math calculation. These scores are lower than would be expected based on her WAIS-IV. She demonstrates strengths and weaknesses consistent with a Specific Learning Disability. According to her self-report, she was previously diagnosed with SLD but did not receive formal intervention during either her primary or secondary education (i.e., only accommodations).

Measures of Attention: To assess for symptoms of inattention and hyperactivity, XXX completed the Barkley ADHD Current and Childhood Symptoms Scales. The Barkley ADHD Current Symptoms Scale is a self-report measure of inattention and hyperactivity symptoms in adulthood, and the Childhood Symptom Scale is a self-report measure of inattention and hyperactivity symptoms that occurred between ages 5 and 12. Each scale comprises 18 items: nine that assess for inattention and nine that assess for hyperactive symptoms. XXX reported clinical levels of childhood inattention (Score = 27) and hyperactivity (Score = 20).

She indicated that she first experienced these behaviors around the 3rd grade, and the symptoms were present in multiple settings. She endorsed clinical levels of both current inattention (Score = 21) and current hyperactivity (Score = 15). These scores suggest ADHD symptoms in childhood and adulthood that meet DSM-5 diagnostic criteria for the disorder. In addition to obtaining self-report data, we administered the Barkley ADHD Current and Childhood Symptoms Scales to XXX's mother. Mrs. Q rated XXX as having exhibited clinical levels of childhood inattention (Score = 27) and clinical levels of childhood hyperactivity (Score = 19). These behaviors were reportedly first observed during elementary school, and the symptoms were present in multiple settings. Mrs. XXX indicated that XXX continues to demonstrate clinical levels of inattention (Score = 25) and hyperactivity (Score = 16) as an adult.

The Test of Variables of Attention (TOVA) is a computerized measure of sustained visual attention. This test is administered for 20 minutes and requires the individual to attend to two easily discriminated geometric images centered on the computer screen. The individual is to respond as quickly as possible to the geometric

shape identified as the target shape before the start of the test. XXX was told not to respond when the non-target geometric shape appears. Instead, the individual presses a button each time the target shape is presented.

The TOVA measures attention by assessing commission and omission errors and response time variability. The first half of the TOVA is designed to elicit omission errors. Omission errors occur when an individual fails to respond to the designated target. These errors reflect inattention. Commission errors occur when the individual incorrectly responds to the non-target shape. These errors are a measure of impulsivity. Finally, a measure of response-time variability is also computed to assess the level of consistency in responding. Inconsistent responses are also reflective of inattention.

There were no indications of an intentional effort to distort her scores or malingering concerning her performance validity. Her overall results were outside normal limits and suggestive of attention difficulties. She obtained clinically significant (low) scores for response time and for response time variability during the first and second quarters; her score for Commission errors was significant during the second quarter and sufficiently low to impact the score for the first half and the Total Commission Errors score. Her Omission Errors score was significant for the first and second quarters, the first half, and the Total Omission Error score.

The TOVA yields an Attention Comparison Score (ACS) that compares the respondent's performance to a sample of individuals independently diagnosed with ADHD. Scores below zero suggest ADHD. XXX obtained an ACS of -3.78, which was well below zero and suggestive of significant attention deficits.

Measure of Executive Functioning: XXX completed the Brown Executive Function/Attention Scales. These self-report scales measure self-perceived functioning across multiple cognitive, behavioral, and emotional domains. On the Activation, Focus, Effort, and Memory scales, XXX scored in the 99th percentile. She described experiencing significant difficulties with organization, prioritizing, and initiating her work. She indicated severe problems with focusing, sustaining attention, shifting attention, sustaining effort, and adjusting processing speed. She endorsed problems with working memory and free recall.

Her score on the Emotion scale (88th percentile) suggests she has some difficulties managing frustration and modulating emotions. On the Action scale, XXX scored in the 98th percentile, suggesting significant difficulties in monitoring and self-regulating or inhibiting behavior. She described herself as highly impulsive. Finally, the combination of scaled scores yields a Total Composite score in the Markedly Atypical range at the 99th percentile. We observed no validity indices for this measure**.**

The Wisconsin Card Sorting Test (WCST): is a test of executive functioning emphasizing problem solving and cognitive flexibility. The computerized version requires the examinee to select one of four presented shapes to complete a sequence of shapes according to a rule that must be inferred from repeated trials with feedback. In addition, the test assesses attention, concentration, working memory, and problem-solving. XXX performed very well, earning scores ranging from Average to Superior. Her Total Errors score was at the 82nd percentile. She made exceptionally few perseverative errors, in combination with the quick completion of the first trial and the total categories achieved. She thus had no difficulty maintaining the set, demonstrating strong cognitive flexibility and problem-solving skills.

Personality & Emotional/Behavioral Functioning: XXX completed the Personality Assessment Inventory (PAI), a 344-item, self-report measure of psychopathology and interpersonal functioning. The test, written at the fourth-grade reading level, comprises eleven clinical scales with corresponding subscales, two interpersonal scales, and five treatment scales that precisely assess risk for suicide, aggressive attitudes, verbal and physical aggression, perceptions of social support, and motivation for treatment. There are also four validity scales for assessing response style and attitude toward taking the test.

Regarding the validity scales, XXX's scores suggest she was attentive to item content and responded consistently to similar items. There are no indications that she attempted to minimize potential symptoms or problems, or that she responded in a socially desirable manner. However, she obtained a clinically significant elevation on the scale, suggesting possible symptom exaggeration. Individuals with similar profiles often elevate this scale to make a "cry for help" or clarify their need for assistance or intervention. This result does not necessarily render her profile invalid, but the results may overrepresent perceived difficulties.

Regarding the clinical scales, XXX obtained clinically significant scores on the Full Scales assessing symptoms of depression and thought-processing problems. The configuration of the clinical scales suggests that XXX may experience significant thinking and concentration problems, accompanied by prominent distress and dysphoria. Regarding cognitive and psychological symptoms of depression, XXX reports several difficulties consistent with a major depressive episode. She indicates thoughts of worthlessness, hopelessness, and personal failure. She may have difficulty with sleep, a decrease in the level of energy and sexual interest, and a loss of appetite or weight changes. She may be despondent much of the time and may have withdrawn from activities she has previously enjoyed. However, she reports only moderate feelings of sadness. This pattern suggests that she may not fully recognize the symptoms as signs of dysphoria and stress, or maybe repressing the experience of unhappiness to some extent.

Regarding thought processing problems, XXX reports peculiarities in thinking and experience. She describes marked confusion, indecision, distractibility, and difficulty concentrating. There were no other Full-Scale elevations. However, she obtained a significant subscale elevation on the scale assessing identity problems. She may be uncertain about significant life issues and perceive having a minimal sense of purpose. People with similar profiles describe themselves as feeling empty, bored, or unfulfilled.

Her sense of self appears to be poorly established, and she may be subject to frequent and unduly harsh self-criticism, and she may struggle with self-doubt. Her self-esteem may be highly vulnerable to slights (intentional or unintentional) by others. It appears she may feel incomplete, unfulfilled, and inadequate. Concerning the treatment scales, there are no indications of problems with aggression or anger control. However, XXX obtained a markedly high score on the scale assessing suicidality, suggesting that she may have active plans for suicide or self-harm. She described herself as having little hope for the future, and potentially in despair, feeling useless or rejected by people around her.

This score suggests the need for immediate intervention and monitoring of potential self-injurious behavior. Her score on the scale assessing perceptions of social support was moderately elevated, suggesting that she has few close interpersonal relationships, conflicted family relationships, or that friends are unavailable when needed. Her scores on the scale assessing attitudes toward treatment indicate a clear interest in and motivation to seek treatment, as well as a positive attitude toward personal change. A key treatment target will be strengthening social support. Collectively, her PAI profile suggests she may meet DSM-5 criteria for a major depressive disorder. There are additionally some indications of borderline personality features.

Clinical Interview Information: When asked about current symptoms, XXX reported ongoing difficulties with attention, affecting her ability to complete schoolwork and manage her time as a college student. Currently, she reports much less anxiety than she had during her freshman and sophomore years. Still, she acknowledged that she experiences depressive symptoms that interfere with her well-being. She said these problems have caused her to disengage from essential activities, that she is not as productive as she could be, that she cries frequently, and that her grades have not been as high as they could have been. However, the client reported that she averages 7 hours of sleep each night, which is adequate for her functioning. In addition, the client reported that her sleep schedule is consistent across the week.

Regarding suicidal and homicidal ideation, the client acknowledged some passive suicidal ideation. The client explained that if she were to die in an accident, she would not care, but noted that she worries about affecting her loved ones. She said that she has a plan (e.g., taking pills) but no intentions to follow through. The client denied active suicidal ideation, and she denied both active and passive homicidal ideation. Regarding pleasurable activities and hobbies, the client reported enjoying hiking, going to the gym, watching TV, cleaning, and lounging. When asked to describe her positive characteristics, the client reported that she is friendly, understanding, funny, patient, loyal, and a good multitasker.

Diagnostic Interview for ADHD in Adults (DIVA): We administered the DIVA, a semi-structured clinical interview that assesses for symptoms of ADHD as described by the Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5), reported for adulthood and childhood. XXX reported numerous symptoms of inattention in adulthood and childhood (ages 5 -12 years). These included: 1) difficulty paying

attention to details, 2) difficulty sustaining attention, 3) listening when spoken to directly, 4) following through on instructions, 5) failing to finish important work, 6) disliking and avoiding tasks that require sustained mental effort, 7) losing important objects, 8) becoming easily distracted by external stimuli, 9) and forgetfulness. Concerning hyperactivity, in adulthood, she said she has trouble with blurting out answers before questions have been completed, and in childhood, with talking excessively, blurting out answers, and waiting her turn. Collectively, her responses suggested she meets DSM-5 criteria for Attention-Deficit/Hyperactivity Disorder – Predominantly Inattentive Presentation.

XXX also completed the Diagnostic Interview for Anxiety, Mood, and OCD and Related Neuropsychiatric Disorders (DIAMOND), a semi-structured, diagnostic interview designed to assess symptoms and behaviors corresponding to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Statistical Classification of Diseases and Related Health Problems (ICD-10) criteria. It contains modules for assessing anxiety, mood, obsessive-compulsive, stress/trauma-related, psychotic, somatoform, neurodevelopmental, and substance use disorders. It also includes a screening tool for suicidal ideation and intent. We administered the self-report screener first to identify the general presence of symptoms. Then, the following modules were administered based on the responses to the screener: obsessive-compulsive and related disorders, anxiety disorders, eating disorders, mood disorders, and neurodevelopmental disorders.

On the obsessive-compulsive and related disorders modules, specifically in response to questions related to body dysmorphic disorder, XXX reported that she spends much time worrying and feeling concerned about the following parts of her body: 1) nose, 2) skin, 3) body fat, 4) muscle mass or tone, 5) breasts, 6) butt and 7) thighs. She reported spending less than an hour a day worrying about her physical appearance, but she said she sometimes cannot concentrate because she is preoccupied with these thoughts.

She said these physical concerns lead to repetitive behaviors such as 1) mirror checking, 2) inspecting her appearance, 3) wearing excessive makeup or clothes to hide her appearance, 4) spending excessive time grooming, and 5) mentally comparing herself to others. However, she indicated experiencing only mild distress and no impairment in functioning. Therefore, it does not appear that she meets the full criteria for the disorder. Regarding hoarding disorder, the client stated that her house is relatively clean, but her room is messy. She reported her room is still usable, suggesting that a diagnosis of hoarding disorder is unwarranted.

For the eating disorders module, specifically concerning a binge-eating disorder, the client endorsed several episodes of binge eating. For example, she eats much more rapidly than expected, becomes uncomfortably full, eats when she is not hungry, eats alone, and feels guilty after the binge-eating episode. For example, during a binge-eating episode, the client reported eating whole pizzas, whole tubs of ice cream, and large portions of peanut butter. In the past month, the client endorsed moderate distress from these binge-eating episodes. However, the client reported only two binges over the last three months, suggesting that a diagnosis of binge-eating disorder is not appropriate. Regarding bulimia nervosa, the client acknowledged vomiting after bingeing twice in the last year, both in the summer, but no other compensatory behaviors.

Regarding her responses to questions in the mood disorder module, XXX reported that she had experienced multiple periods of at least two weeks during which she felt sad, blue, down, or depressed. Regarding specific symptoms, the client said that during the two weeks, she experienced 1) significant changes in appetite, 2) insomnia, 3) feeling agitated so much that others noticed, 4) fatigue, 5) feelings of worthlessness, 6) difficulty concentrating and thinking, and 7) suicidal ideation. She reported that she experienced significant distress and impairment at school during these periods, with family, home responsibilities, social life, and leisure activities. She denied using any medications, substances, or medical illness or injury before the onset of these two weeks. These findings suggest that XXX has experienced multiple major depressive episodes over the past five or more years. Regarding persistent depressive disorder, the client denied a sustained period of two years during which she consistently felt despondent, blue, down, or depressed.

On the anxiety disorders module, and concerning symptoms of panic disorder, the client reported having experienced periods of fear (e.g., feeling like she is going to die) and uncomfortable physical sensations (e.g., sweating, pounding heart, and feeling faint) that come out of nowhere and reach a peak within minutes.

However, the client denied ever having a panic attack that was unexpected with no apparent trigger. Regarding symptoms of agoraphobia, the client endorsed feeling very afraid or anxious when using public transportation, like buses and planes. However, the client denied experiencing fear or anxiety in enclosed spaces, open spaces, crowded places, or being alone outside of the home. Her responses to the DIAMOND suggest that she meets full DSM-5 criteria for Major Depressive Disorder, Recurrent Episode, In Partial Remission.

Summary & Integration of Assessment Results

XXX is an XX-year-old female referred by the SIU Student Health Center for a psychological evaluation for formal assessment of attention and learning problems and to facilitate treatment planning. The results of the current testing suggest that she is functioning within the average range of intellectual ability. She demonstrates well-developed skills in verbal reasoning, nonverbal reasoning, and processing speed. However, she exhibited a significant weakness in auditory working memory, specifically on a timed test of mental arithmetic problems. In addition, her scores for academic achievement were generally lower than expected for basic reading and mathematical calculation, both in the Low Average range. These scores are consistent with her self-reported history of specific learning disorders in reading, mathematics, and written expression.

Concerning attention problems, XXX reported having a prior diagnosis of attention-deficit hyperactivity disorder, which her mother corroborated. The results of current testing are mainly consistent with this diagnosis. In addition to her low score on the Working Memory Index of the WAIS-IV, she obtained poor scores on the Test of Variables of Attention. Her scores on the Brown Executive Function/Attention Scales, the Barkley Self and Other Report scales of ADHD, and her responses to the DIVA all support a diagnosis of ADHD-Predominantly Inattentive Presentation (ADHD-PI). Moreover, her transcripts demonstrate a history of academic difficulties. In sum, she appears to meet full DSM-5 diagnostic criteria.

Concerning emotional and behavioral functioning, XXX has a history of seeking mental health services to treat depression and anxiety. Current testing results indicate that she has met full diagnostic criteria for major depressive disorder, recurrent episode, in partial remission. We based this diagnosis on her responses to the Personality Assessment Inventory (PAI) and the DIAMOND. It appears that she continues to struggle with some symptoms, although she denies that she is currently experiencing a full episode. Her self-description on the PAI is of significant concern, as she endorsed experiencing significant suicidal ideation and other thoughts of self-harm. Although she denied active ideation and intent at the time of testing, it appears this will be important to monitor. She reported a desire for treatment, and we highly recommend individual therapy. Given that she described considerable difficulties in relationships and social support, Interpersonal Psychotherapy for depression (IPT) may be very beneficial.

XXX acknowledged chronic (daily) cannabis use during the clinical interview. However, it appears that she uses cannabis for relaxation and coping purposes. Although she did not report any problems related to substance use on any of the measures, it is essential to note that studies have demonstrated that habitual use of cannabis can have a markedly negative impact on attention, concentration, and memory functioning. It can also contribute to mood disturbance and emotional dysregulation. Therefore, reducing or eliminating marijuana consumption may significantly improve her overall functioning. In summary, XXX meets the full criteria for ADHD-PI and demonstrates the need for accommodations. She appears to be struggling with some significant symptoms of depression and may benefit from continued intervention. In addition, she possesses numerous strengths to build, including well-developed verbal and nonverbal reasoning skills, substantial academic achievement, motivation, and persistence to set and meet goals.

Diagnosis

F90.0 Attention Deficit Hyperactivity Disorder – Primarily Inattentive Type (Mild)
F33.41 Major Depressive Disorder, Recurrent Episode, in Partial Remission

Recommendations

1. XXX may require the following accommodations:
   a. Extra time when taking exams.

b. Access to a private and quiet testing room when taking exams.
c. Preferential seating near the front of the class to avoid distractions

2. XXX may wish to consider the following strategies to maximize her academic performance:
   a. Consider buying a reading pen to improve comprehension.
   b. Consider the time of day during which she performs at her best, and schedule classes during that time. For example, XXX should avoid scheduling classes during times when she is likely to be tired.
   c. Choose seats in less distracting areas, such as away from windows, air conditioners, or talking people.
   d. Avoid overloading the schedule with challenging classes in a single semester. A heavy workload with challenging materials may require cognitive performance that is too demanding.
   e. Seek out the phone numbers and working alliances of at least two classmates in each class for help with material and questions, if needed.
   f. To enhance reading comprehension, consider reading the material aloud in a quiet, private room.
3. XXX appears to be struggling with symptoms of depression and has met the full criteria for major depressive disorder in partial remission. Symptoms of depression can exacerbate problems with attention, concentration, and decision-making.
   a. She may benefit from individual therapy to address dysphoria, and Interpersonal Psychotherapy (IPT) for Depression may be particularly effective.
   b. XXX has described experiencing a variety of interpersonal difficulties. Therefore, she may benefit from Dialectical Behavior Therapy (DBT) Skills training. All the modules, namely Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness skills, may be very helpful.
4. XXX acknowledges daily marijuana use, which may be contributing to problems with attention, concentration, memory, and mood dysregulation. She may benefit from Cognitive Behavioral Therapy for Cannabis Users with an emphasis on coping skills and relaxation training. DBT skills training may also be helpful in this regard.
5. XXX may benefit from pharmacotherapy for attention problems or symptoms of depression. We advise her to consult with her health care provider.

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Bryant Stone, PhD
Licensed Clinical Psychologist
Maryland License Number: 07258
PSYPACT Mobility Number: 24350

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Date

WAIS-IV

Index	Standard Score	Percentile	95% CI	Range
FSIQ	101	53	97-109	Average
GAI	104	61	99-109	Average
VCI	108	70	102-113	Average
PRI	100	50	94-106	Average
WMI	83	13	77-91	Low Average
PSI	108	70	99-116	Average

Subtest	Scaled Score	Percentile
Similarities	15	95
Vocabulary	13	84
Information	7	16
Block Design	6	9
Matrix Reasoning	12	75
Visual Puzzles	12	75
Digit Span	9	37
Arithmetic	5	5
Symbol Search	12	75
Coding	11	63